Service Planning Area 3
County of Los Angeles – Department of Mental Health
Quality **I**mprovement **C**ommittee

Meeting Minutes
September 15, 2010

Welcome and Introductions

All members introduced themselves and Seth welcomed and thanked everyone for coming.

Attendees

Misty Allen	Michelle Hernandez	Linda Pry
Gloria Santos	Windy Luna-Perez	Judy Law
Catherine Weatherspoon	Melody Taylor Stark	Rosa Macilla
Stella Tam	Sandra Bourdaa	Carrie Chung
Julia Soler	Rhiannon DeCarlo	Dustin Schiada
Paula Randle	Padma Durvasula	Stephanie Schneider
Nancy Uberto	Rebecca DeKeyser	Elizabeth Owens
Saundra Lockwood	Reina Perez Vidauri	Ilda Aharowian

Previous Minutes:

> *Clarification*: QA 24.0 hour facility cannot claim on discharge, but Outpatient can bill because the hospital is not billing on the day the client is discharged.

Previous minutes were reviewed and approved.

Presentation

QA Questions and Answers

Jennifer Eberle
LAC-DMH Quality Assurance

Quality Assurance

> Defined as clinical documentation; procedure codes, taxonomy; anything to due with documentation.

Question: What needs to be on CCCP – specifically listed on CCCP?

Answer: "EBP" does not need to be specifically stated on CCCP. CCCP is what is used to cover medi-cal requirements. EBP's – require that you have all of the requirements as outlined by the developer. You should ensure that the goals on your CCCP match to the services you are providing in the EBP.

Question/Comment: Can clients be seen if they are open elsewhere?

Answer: Clients can be seen if they are open elsewhere. The service providers should be coordinating services with each other. Clients can be opened at one agency even if they are open elsewhere. Providers were encouraged to call Dr. Meyers if they have further questions about this.

One client reportedly called Patient's Rights because of frustration with the process of not being able to receive services. The discharge episode procedure is an internal administrative process and should not get in the way of clients receiving needed services.

Cycle Dates:

Complications related to cycle dates may be one reason why agencies sometimes refuse to open cases. Reassurance from the other agency that they will be closing a given case (if that is what is occurring) should be done so that the agency receiving the transfer can use their own cycle date.

Technically if there are two open episodes, the receiving agency would not use a new cycle date.

Documenting correspondence with the other agency about admission dates is helpful for auditors to see when a case was opened.

If an episode is not closed in the transferring agency, the SFPR can still be transferred to the receiving agency.

If the chart has been closed for two years, the new agency can use their own cycle date.

The Rule: If you have tried twice to get the SFPR removed with no success, a letter to your Service Area District Chief is strongly encouraged.

Document the date; who you spoke to at the previous agency; summary of the conversation.

Letter has to go to the existing service area District Chief (**not** the receiving areas District Chief).

If there are multiple open episodes, in order to use your own cycle date, you would need to get assurance from all agencies when they will be closing.

Email Jennifer if you have more specific questions.

Question: What are the programs that absolutely must be SFPR?

Answer: There is currently "no policy" - still in draft form and it is actually been revised again (SFPR and SFPR guidelines). Draft policies state, "intensive service providers that included SFPR; WRAP Around, Intensive Foster Care." Currently, SFPR can be anybody. A provider that doesn't have an Authorized Mental Health Discipline (AMHD) can be SFPR. Staff should not be trained on any policies until they have been approved. Not recommended to have student interns as SFPR.

Previously QIC SPA3 meetings have strongly encouraged that SFPR's should only be clinicians. Jennifer indicated this was draft policy. "You do not have to be licensed to be SFPR." Agencies can adopt a higher standard.

Correction by Jennifer of what she said at the meeting: The SFPR policy currently in place and finalized does state that intensive service providers shall become the SFPR which includes Wraparound.

Question: What are the documentation standards for Case Managers and Peer Advocates?

Answer: Peer Advocates and Case Managers can't do assessing / assessments. For CCCP's, anyone can write a goal if their supervisor has approved them to write goals. In these cases, the supervisor signs off as AMHD (formerly known as LPHA). LAC-DMH just requires an intervention for the client clearly documented in the Progress Notes. There are no documentation standards for Case Managers and Peer Advocates. Peer Advocates in directly-operated programs cannot bill direct services. Community workers, in directly-operated programs, and Case Managers can write progress notes.

Question: Can a Case manager or Peer Advocate document it if they see that someone's depression and anxiety has been reduced?

Answer: Jennifer Eberle facilitates Paraprofessional Training for directly-operated programs. Once directly-operated staff become a community worker they can do progress notes.

Therapy notes Vs. Rehab notes. Generally, if you're talking about processing feelings, or exploring where feelings are coming from, clinicians should be providing this intervention.

Non-clinicians: Focus on observations. Don't write "bizarre behavior," write specifically what the client was doing. You can quote what a client has said.

Example: A Case Manager can write "client crying" rather than "client was depressed."

Case Managers should document what they saw, they shouldn't interpret what the client was doing. Case Management notes should be less abstract and more concrete. Try to be as matter of fact as possible.

Jennifer noted, do not leave room for interpretation in progress notes

Directly-operated programs do not allow Community Workers to be the rendering provider in Crisis Intervention. However, community workers can be a support, or participating staff, in the crisis intervention note.

Psych Techs can *assess the situation*, but they ***cannot assess a client***.

FSP Case Managers – are coming in crisis or borderline crisis. The notes are written like therapy notes. Too many case managers are stepping out of their scope. FSP Case Managers notes are stating clients are coming in wanting to talk about how depressed they are. The agency has recommended the case managers in these cases refer the client to the therapist. A lot of re-training is needed. LAC-DMH highly stresses that agencies do these types of re-trainings.

Example: How to help redirect the client – go back into the Rehab position rather than focus on exploring the feelings.

T1017 Procedure Code. Staff are documenting multiple service types or multiple services (on different days) of TCM on one progress note. Each different service type or day of service requires a different note. LAC-DMH strongly encourages Supervisors to monitor notes to improve documentation.

Question: What is DMH's expectation about writing out Case Manager versus CM?
Answer: Can use an acronym if it is widely established in the field. Agencies are encouraged to have an acronyms list when auditors comes so they will understand. *When in doubt, write out.*

Question/Comment: Writing Discipline and Title
Answer: Don't have to write both discipline and title. If you have a specific discipline, write that. If not, use your job title.

Question: Who can use H2015?
Answer: Anyone if it is within your scope of practice. Scope of Practice should be outlined clearly by each agency.

Question: Whatever happened to H0046?
Answer: This code only replaced therapy over the phone, or face-to-face therapy less than 19 minutes.

Question: H0046 & Family therapy – can we use this code if the client is present and in the office while the parent is speaking with the therapist on the phone?
Answer: The procedure code would be 90847 (family therapy) – you can NOT mark the phone box and have face-to-face time. If you mark telephone, face-to-face time **MUST** be zero time. So, in this example, mark face to face since the client is present, do NOT mark the telephone box but be sure to document in your note that the parent was on the phone.

EBP Questions

The documentation standards have not changed, where it gets tricky is the documentation and the EBP.

Question/Comment: Billing certain codes in the PEI Plan

Answer: Codes that are not set up under the PEI plan include: psychological testing (unless you request a PFAR to have this code added), therapeutic behavior services, G9007 (MAT code), and Crisis Intervention. EBP's are more intervention-based. Make sure you don't go away from the CCCP goals and objections to meet the PEI requirements.

If it is listed as an ancillary service or core service, you choose the PEI plan. The core service and ancillary services can be billed under PEI. If it is not a core service, use a service strategy or Option 1 EBP/SS code. If it is not an ancillary or core service, it will be billed under a different funding source such as another MHSA plan or Wraparound, etc.

Question: Will there be a separate audit for EBP's?
Answer: Medi-Cal EPSTD audits will not focus on EBPs.

Question: Can we list a support group at Wellness Centers on the Coordination Page of the CCCP?
Answer: Peer Support group is not claimable to Medi-Cal. Suggest listing it as additional client contacts on the first page of the CCCP.

Question: Are stamped signatures by the supervisor okay by Medi-Cal standards?
Answer: If it is an agency requirement, and is NOT a required signature by Medi-Cal (i.e the person providing the service), it may be okay. The industry and LAC-DMH prohibits stamped signatures for required signatures (Confirm with Jennifer Eberle if you use stamped signatures at your agency). The industry overall and LAC-DMH requirements prohibit stamped signatures.

Question: Should the 90801 Assessment code only be used face-to-face with the client?
Answer: Yes, 90801 is only for face to face. Other codes can be used for assessment purposes and you can write on the note "For assessment purposes……talked with parents…."

Question: Can the diagnosis be written in progress notes?
Answer: For directly operated providers – diagnosis should only be in two places, the Initial Assessment form and Diagnosis Information form.

Note: Don't look for all documentation for Medical necessity in progress notes, or on initial assessment progress notes. The initial progress note does require more than "gathered assessment info…" don't have to say "client meets medical necessity because…." This also applies to the Annual Assessment Update as well. If it is documented in the assessment, you don't have to repeat it.

In Triple P, most of the services are Collateral. There are two sessions that require the client to be present. You still need to respond to the requirements of Medi-Cal. **Two separate notes** need to be written because two services were provided.

Announcements

The DMH Service Area 3 QIC back-up staff member to Dr. Meyers is Dr. Ilda Aharonian, a Contract Monitor for several agencies in Service Area 3.

The DMH Recovery-Oriented Documentation Training was designed to assist people with understanding the Clinical Loop and the Recovery Model.

- Rosemary Children's School, a Non-Public School, received the WASP accreditation. Congratulations!

Quality Improvement

Geo mapping: EBPs
- Item feedback: EBP's list will be completed – received this request from other service areas; should be coming out in the next few months

Cultural Competency: Plan Deadline Extension
- End of November

Risk Management: Updates to the Clinical Incident (Event)
- Clinicial Incident Notification Form
  - Changed – Policy Updated
  - Field #7 – Service Area
  - Field #9 – modified for clarification of MHSA or other program
  - Field #12 – added nurse practitioner
  - Field #15 – updated for more specific – refers to medication and relates to Field #22.
  - Manager's Page – reference back to Field #15
  - This document is not kept in the client's chart

New State Appeal Process

- ❖ DMH audit appeals process (EPSDT audit disallowances process). Can actually go straight to the state to appeal rather than going through LAC-DMH.

APS/EQRO Group Guidelines Revision (External Quality Review Organization)

- ❖ All agencies will receive guidelines tailored specifically to the site which is being visited.

Quality Assurance

Registration/Licensure with Boards

- ❖ if a staff member's registration expires, that staff member needs to maintain their license.

ASW, MFT Intern, Psychologist Intern: State Board Registration

New Online Training
DMH QA is developing an online training and will be providing initial assessment training

Assessment Training Schedule: Countywide Children's QIC & SPA 3

- ❖ SPA3 – Tuesday, November 16th 8:00 a.m. – 12:00 p.m. Will not include the ICARE (Birth to Age 5) Assessment. The November 16th training will include the adult and child assessment.
- ❖ November 18th 8:00 a.m. – 12:00 p.m. – for Childrens QIC. Registration: Please contact Terra Mulcahy. Tmulcahy@lacounty.dmh.gov

NOA Form for Medi-Cal Beneficiaries

- ❖ Notice of Action form - for use when you determine that the client does not meet medical necessity.
- ❖ NOA informs beneficiary of some changes in MHS and their rights to appeal.

Other Issues

Trainings

- ❖ 0-5 MHSA Trainings

Audits

- ❖ EPSDT – we do not anticipate any audits until there is a state budget.
- ❖ We do not anticipate any new audits until the beginning of the new year.

Adjournment